

IEM's AI Modeling: Short-term COVID-19 Projections

Date: 10/6/21

Leveraging over 15 years of support to HHS for medical consequence modeling and our proprietary artificial intelligence (AI) models, IEM believes that our Coronavirus model outputs can be used to assist localities and their medical facilities to better prepare for an increase in hospitalizations, to better plan for and locate drive-through testing facilities, and to determine where increased levels of transmission may be occurring.

We have been refining our AI model over the past month and are confident in its ability to provide accurate 7-day projections that can be used for operational and logistical planning.

AI-based Model Background

IEM is currently using an AI model to fit data from various sources and project new cases of COVID-19. We do not assume the average number of secondary infections (R-value) stays the same over time. IEM's AI model finds the best R-value over time to evaluate how it changes over the course of the outbreak. The IEM modeling team is running ~11 million simulations to fit each state's data and using the best fit for the R-value to project new cases over the next 7 days. The AI models are executed on a daily basis to evaluate the changing dynamics of the COVID-19 pandemic. Our projections have typically been within 10%, and are often within 5%, of actual confirmed cases.

The projections shown in this document are based on data pulled in as of 10/6/21 9 a.m.

Please provide any feedback or send any questions that you might have to us. We are continually updating and improving the model, so your feedback is critical.

Also, if you have more current or refined data for your State, Commonwealth or Territory that you would like IEM to factor in, please let us know.

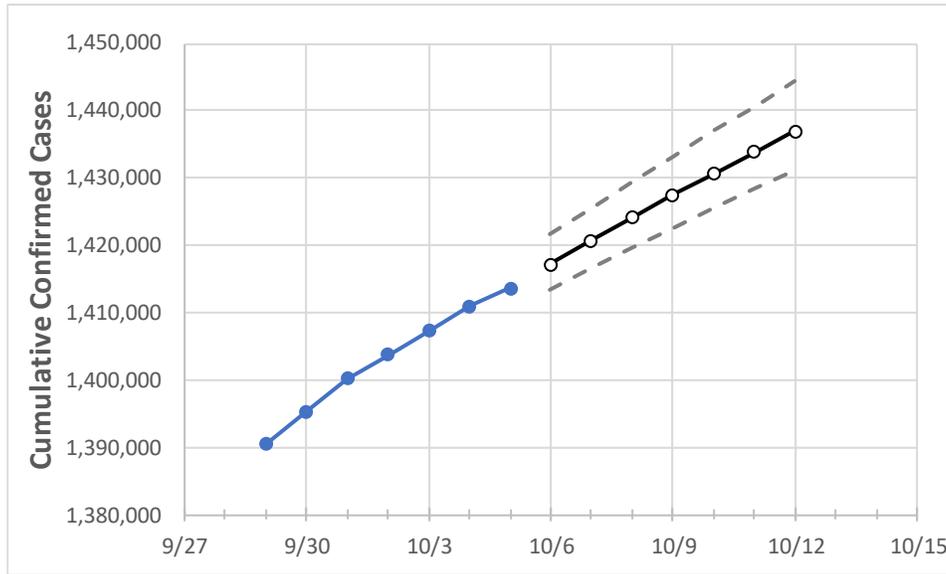
IEM's Modeling Lead

Dr. Prasith "Sid" Baccam is a **Computational Epidemiologist expert** at IEM with more than **20 years of experience in medical consequence modeling and simulation of disease outbreaks** and medical consequences following hypothetical attacks with biological agents or emerging infectious diseases. He develops key simulation models and decision support tools at IEM, specializing in public health, disaster response, and medical countermeasures (MCM) to enhance data-driven decision making and improve modeling assumptions.

Upon receiving his **Ph.D. in Applied Mathematics and Immunobiology** at Iowa State University, Dr. Baccam worked as a Postdoctoral Research Associate at Los Alamos National Laboratory where he focused on researching viral and immunological modeling. After his stint at Los Alamos, Dr. Baccam has served as Task Lead in multiple public health projects have allowed him to develop expertise as a mathematical biologist and a leader on high-performance modeling and simulation teams.

He has worked with state and local public health officials as well as Federal agencies, including **HHS**, the Centers for Disease Control and Prevention (**CDC**), and the Department of Homeland Security (**DHS**). Dr. Baccam has published numerous papers on public health response models and implications on policy and has been invited to participate in workshops and symposiums held by the Institute of Medicine (now the National Academy of Health). His modeling results have been briefed to the **Executive Office of the President** and informed two presidential policy actions.

North Carolina State Projections



	Actual Confirmed Cases On:				Projected Cases For:						
	10/2	10/3	10/4	10/5	10/6	10/7	10/8	10/9	10/10	10/11	10/12
North Carolina	1,403,779	1,407,340	1,410,902	1,413,586	1,417,194	1,420,690	1,424,109	1,427,450	1,430,678	1,433,895	1,437,034

Note: The State's projection shows a "best estimate" curve (the solid line with circles) and the dotted lines are the upper and lower estimates around that best estimate. Our projections have typically been within 10%, and are often within 5%, of actual confirmed cases.

North Carolina Counties

	Actual Confirmed Cases On:				Projected Cases For:						
	10/2	10/3	10/4	10/5	10/6	10/7	10/8	10/9	10/10	10/11	10/12
Cumberland	42,481	42,616	42,750	42,867	43,018	43,170	43,314	43,458	43,611	43,769	43,916
Durham	33,175	33,244	33,313	33,341	33,404	33,467	33,530	33,589	33,650	33,711	33,767
Guilford	64,186	64,404	64,621	64,746	64,957	65,169	65,375	65,583	65,782	65,984	66,183
Mecklenburg	151,154	151,462	151,771	152,121	152,439	152,742	153,046	153,339	153,628	153,916	154,203
Orange	11,262	11,296	11,329	11,345	11,381	11,418	11,453	11,489	11,526	11,562	11,599
Union	34,621	34,703	34,784	34,852	34,929	35,005	35,080	35,150	35,219	35,285	35,352
Wake	123,640	123,947	124,253	124,390	124,670	124,928	125,195	125,453	125,704	125,951	126,189

Some recipients of our daily COVID-19 short-term (7 day) projections have requested projections of demand for: hospital bed, intensive care unit (ICU) beds, and mechanical ventilation. We realize that different states and localities will have different characteristics for hospital demand of COVID-19 cases, and we are presenting the best assumptions we could find for those medical demands based on scientific literature and health data reporting. Specifically:

- **Beds:** For hospitalization, we use a range of 10% and 20% of cases require hospitalization based on CDC's report ([MMWR, March 18, 2020](#)) and state reports of COVID-19 cases.
- **ICU:** The CDC report found that 24% of hospitalized cases require ICU care.
- **Ventilators:** Based on clinical data from China and state reports, we assume that 50% of ICU cases require a ventilator.

If you have other estimates for these assumptions, please share them with us as we work to refine our modeling, assumptions, and data on a daily basis.

The medical demands shown in the table assume 20% of **cumulative** confirmed cases require hospitalization. To get the medical demand for the assumption that 10% of confirmed cases require hospitalization, simply divide the demand by 2.

North Carolina Medical Demands by County

	Actual Confirmed Cases On:				Projected Cases (Hospitalized) [ICU] {Ventilator} For:											
	10/2	10/3	10/4	10/5	10/7			10/9			10/11					
Cumberland	42,481	42,616	42,750	42,867	43,170	(8,634)	[2,072]	{1,036}	43,458	(8,692)	[2,086]	{1,043}	43,769	(8,754)	[2,101]	{1,050}
Durham	33,175	33,244	33,313	33,341	33,467	(6,693)	[1,606]	{803}	33,589	(6,718)	[1,612]	{806}	33,711	(6,742)	[1,618]	{809}
Guilford	64,186	64,404	64,621	64,746	65,169	(13,034)	[3,128]	{1,564}	65,583	(13,117)	[3,148]	{1,574}	65,984	(13,197)	[3,167]	{1,584}
Mecklenburg	151,154	151,462	151,771	152,121	152,742	(30,548)	[7,332]	{3,666}	153,339	(30,668)	[7,360]	{3,680}	153,916	(30,783)	[7,388]	{3,694}
Orange	11,262	11,296	11,329	11,345	11,418	(2,284)	[548]	{274}	11,489	(2,298)	[551]	{276}	11,562	(2,312)	[555]	{277}
Union	34,621	34,703	34,784	34,852	35,005	(7,001)	[1,680]	{840}	35,150	(7,030)	[1,687]	{844}	35,285	(7,057)	[1,694]	{847}
Wake	123,640	123,947	124,253	124,390	124,928	(24,986)	[5,997]	{2,998}	125,453	(25,091)	[6,022]	{3,011}	125,951	(25,190)	[6,046]	{3,023}

For additional information from IEM, please contact Bryan Koon, Vice President of Emergency Management and Homeland Security at bryan.koon@iem.com or 850-519-7966 or Stephanie Tennyson at stephanie.tennyson@iem.com or 202-309-4257.